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ABSTRACT

This paper describes methods developed by the University of Wisconsin Regional Rehabilitation Research Institute (UW-RRRI) to help identify difficult and challenging rehabilitation cases before services begin. Several scales are described in the paper; the first, the Handicap Problems Inventory, a forerunner to UW-RRRI measurements, is published by Purdue Test Publication and is the best single predictor of case difficulty. It also helps to evaluate the degree of disability impact and to select issues for counseling. The Rehabilitation Gain Scale measures the vocational and extravocational impact of rehabilitation services on clients; administering the scale as acceptance provides a diagnostic measure of rehabilitation potential and case feasibility. The Rehabilitation Need and Status Scale measures a client's rehabilitation-related functioning before, during or after services and helps assess his unmet needs and how to satisfy them. The authors feel that advance knowledge of difficult cases should help practitioners and administrators program for these clients and provide them with more effective services. References are included. (Author/SES)

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Abstract

We know that some disabled persons present a greater challenge to rehabilitation than others but often have difficulty recognizing "high risk" cases before services begin. The staff of the University of Wisconsin Regional Rehabilitation Research Institute (UW-RRRI) has developed methods to help identify difficult cases at acceptance.

The "Rehabilitation Gain Scale" measures the vocational and extra-vocational impact of rehabilitation services on clients. Administering the scale at acceptance provides a valuable diagnostic measure of rehabilitation potential and case feasibility.

The procedure to measure "rehabilitation sustention" is an indicator of how well clients retain the benefits of services for months or years afterward. It helps predict rehabilitation potential and feasibility on a longitudinal basis.

The "Rehabilitation Need and Status Scale" measures a client's rehabilitation-related functioning before, during, or after services, based on Maslow's theory of basic human needs. This instrument helps assess a client's unmet needs and how to satisfy them. The type and degree of chance necessary indicates case feasibility.

A forerunner of the UW-RRRI measurements and the best single predictor of case difficulty is the "Handicap Problems Inventory," published by Purdue Test Publications. It helps evaluate the degree of disability impact and select issues for counseling.

Advance knowledge of which type of case may be "tough" should help practitioners and administrators to program for these clients and provide them with more effective services. Quality services are manifested through the successful rehabilitation of an exceptionally-handicapped person.

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WHO ARE THE TOUGH REHABILITATION CASES?

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We all know that some disabled persons present a greater challenge to rehabilitation than others. How can a rehabilitation worker recognize these "high risk" cases before he begins working with a client?

This question is being studied in depth at the University of Wisconsin-Madison Regional Rehabilitation Research Institute (RRRI). It is now possible to isolate some of the characteristics identifying the difficult cases, characteristics to alert the rehabilitation worker that here is an applicant who needs his best efforts and skills.

There are several different kinds of approaches in identifying case difficulty. Assessment can be based on two types of client information. The first is demographic data, providing information about the client's personal history: age, sex, education, type of disability, employment history, and the like. The second is measurements from formal instruments, including tests taken by the client and questionnaires answered by other people with whom he has contact (e.g., the counselor, the parents).

The Handicap Problems Inventory (HPI), published by the Purdue Test Publications, falls into the second category of client information. The HPI (19) was the result of the first research effort to measure the practical impact of being disabled on an individual's life. It is a half-hour test covering 280 common handicap problems in four practical areas of daily living: familial, social, vocational, and personal. Administration of the inventory has proven that disabled people, through their re-

sponses to the HPI statements, are able to provide an accurate assessment of the types and degrees of their handicaps. Research on the HPI also has supported the belief that rehabilitated persons have fewer handicap-related problems than non-rehabilitated persons.

By administering the HPI to clients, the rehabilitation worker can gain an understanding of the client's feelings about his disability and how it affects his daily functioning. For example, deaf people report having fewer family problems but experiencing greater degrees of social maladjustment than disabled individuals who do not have communication impairments. The HPI results can isolate similar unique problems for other types of disabilities. Furthermore, research on the HPI has indicated that the score is significantly, statistically related to the client's sex, intelligence, length of disablement, age at onset of disability, severity of impairment, source of referral, completion of a program of state vocational rehabilitation services, the type of vocational rehabilitation services received, and the like. By comparing the HPI score to these other variables, the rehabilitation worker obtains a clearer picture of the degree of the client's handicap and the program needed for successful rehabilitation.

In addition to helping the rehabilitation worker assess the degree and general area of disability impact, the HPI score provides the worker with relevant information about the issues that need to be discussed in counseling. Because the individual items state specific problems that often result from being disabled, the professional worker is informed of counseling issues that seemed important to his client when he answered the HPI questions. This, incidentally, is a relatively safe technique because it avoids probing into unrecognized anxieties or the dangerous breaking down of defenses. On the other hand, when a client admits to a specific problem (e.g., rejec-

tion by a parent) he is probably ready to talk about it. In fact, this is a way of asking for help with less embarrassment.

The UW-RRRI has studied rehabilitation case difficulty levels in a number of other ways as well. Hammond, Wright, and Butler (7) developed a "Feasibility Scale" to measure a client's rehabilitation potential. It includes HPI scores and demographic client data to predict the success of applicants for rehabilitation. Reagles, Wright, and Butler (14) developed a "Scale of Rehabilitation Gain" to measure the vocational and extra-vocational impact of rehabilitation services on the client. The scale is designed to be administered before and after rehabilitation services, thereby indicating what the client "gained" as a result of receiving services. In a conceptual departure, a "Rehabilitation Client Satisfaction Scale" was developed (15) that measures how the individual who has been served regards the benefits received from the counselor and the program in general. The latest published research in this area was by Gay, Reagles, and Wright (6) who developed a procedure, using the RRRI's Gain Scale, to measure "rehabilitation sustention"--how well clients retain the benefits received from vocational rehabilitation services for months or even many years after the termination of services.

At the present time the Wisconsin group is developing a new instrument, which may be called the "Rehabilitation Status Scale," that will measure a client's rehabilitation-related functioning at any point before, during, or after rehabilitation services. Shlomo Kravetz, the doctoral candidate who is working on this instrument, is adapting the scaling approach to Maslow's theory of a hierarchy of human needs.

The studies that have been and are being conducted at the University of Wisconsin RRRI and elsewhere (1, 3, 4, 5, 8, 9, 10, 11, 12, 13, 16, 17,

18) have made it possible to isolate those client characteristics that usually are associated with a "tough" rehabilitation case. While there is not always absolute agreement in study results, the following indicators of case difficulty seem valid:

-- making a high score on the four HPI scales (familial, social, vocational, and personal) indicating many self-perceived problems,
-- making a low score on the Pre-rehabilitation Level Scale (of the Rehabilitation Gain Scale),
-- performing poorly on intelligence and achievement tests,
-- being a member of a particularly "vulnerable" client group, such as the elderly or the multiply and severely disabled,
-- being single and having no dependents and few (if any) property acquisitions,
-- having a negative employment history, such as being unemployed for long periods of time, earning low weekly wages, having depended on some type of welfare support,
-- having no vocational training and possessing few job skills,
-- having indefinite or unrealistic plans for the future,
-- being disabled later in life and having other medical problems (e.g., alcoholism) in addition to the disability
-- having had fewer years of formal education or being mentally retarded,
-- having a "poor" family relationship and receiving little financial support from the family,
-- having few friends, leisure-time activities, and social skills,
-- having weak ego-strength and a negative self concept,
-- having severe or long-standing psychiatric problems.

How does information on who might be a tough rehabilitation case help accomplish better practice? Certainly not by misuse to avoid serving those who need help the most. Case difficulty should not be equated with predicted failure. But advance knowledge of which type of case may be tough should help agencies and professionals alike to program for these clients by budgeting extra time and case service funds. It also seems reasonable that the successful closure of the more difficult-to-rehabilitate cases should carry extra credit for the rehabilitationist and his agency. Incidentally, one of the RRRI studies (2) demonstrated that trained, i.e., master's degree, rehabilitation counselors are more willing to accept and work with difficult, severely disabled clients than untrained workers are. On the other hand, it is unreasonable that rehabilitation services should be limited only to the extremely handicapped; the moderately limited also have a right to equal opportunity in life and often make their mark with just a little extra help--a fantastic benefit-cost outcome for rehabilitation.

"Tokenism" is a devastating accusation that should not be leveled against rehabilitation, either the agency(s) or the profession. Practitioners must not avoid tough cases in an effort to get easy closures. Better understanding by practitioners of difficulty indices will help them prepare for more effective services to the more difficult-to-rehabilitate clients. Administrators armed with this knowledge should have a better understanding of case service quality and appropriately balance the assessment of the worker's performance against the number of cases processed during a year. There is certainly no better public relations for agency image than the quality of rehabilitation services--demonstrated by the successful rehabilitation of an exceptionally-handicapped person.

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